DOCUMENT RESUME

ED 482 289 TM 035 375

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TITLE The Efficacy of Exposure-Based Cognitive Therapy with Survivors of Childhood Sexual Abuse.

PUB DATE 2003-11-00

NOTE 11p.

PUB TYPE Reports - Descriptive (141)

EDRS PRICE EDRS Price MF01/PC01 Plus Postage.

DESCRIPTORS *Adults; Child Abuse; *Children; *Cognitive Psychology; Outcomes of Treatment; Sexual Abuse; *Therapy

IDENTIFIERS Child Abuse Survivors; *Sexual Abuse Survivors

ABSTRACT

Recent research has revealed the efficacy of cognitive behavioral interventions with sexual abuse survivors. Cognitive behavioral treatment (CBT) interventions require trauma survivors to confront their painful memories directly. This allows for assessment of cognitive distortions that need to be challenged and reframed. The extent and amount of confronting, or re-exposing the survivor to the traumatic memories is often a delicate and controversial issue. A common question in therapy with sexual abuse survivors is whether to expose or not expose the survivor to the traumatic events in order for healing to take place. This paper provides a rationale for the efficacy of using exposure-based CBT in treating adult sexual abuse survivors. A brief overview of CBT methods will be presented. (Contains 15 references.) (Author/SLD)

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ED 482 289

Running head: EXPOSURE-BASED CBT WITH CSA SURVIVORS

The Efficacy of Exposure-Based Cognitive Therapy with Survivors of Childhood Sexual Abuse

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Abstract

Recent research has revealed the efficacy of cognitive behavioral interventions with sexual abuse survivors. Cognitive behavioral treatment (CBT) interventions require trauma survivors to directly confront their painful memories. This allows for assessment of cognitive distortions that need to be challenged and reframed. The extent and amount of confronting, or re-exposing the survivor to the traumatic memories is often a delicate and controversial issue. A common question in therapy with sexual abuse survivors is whether *to expose* or *not expose* the survivor to the traumatic events in order for healing to take place? This paper provides a rationale for the efficacy of utilizing exposure-based CBT in treating adult sexual abuse survivors. A brief overview of CBT methods will be presented.

The Efficacy of Exposure-Based Cognitive Therapy with Survivors of Childhood Sexual Abuse

Identification of Problem Area

It has been suggested that humans possess an Adaptive Information Processing (AIP) system that adjusts to minor disturbances of everyday life (Shapiro, 2003; Shapiro & Maxfield, 2001). However, when the brain is exposed to traumatic experiences, the memories of those events may be stored differently than ordinary memory. Rather than processing the traumatic event as related thoughts, images, emotions and sensations, the information is stored in fragmented and disconnected forms on the right side of the brain, separate from the brain's language center (Bradley, 2002; Parnell, 1999; Shapiro & Maxfield, 2001).

One form of trauma that has physical, emotional, and psychological repercussions on the development of persons is childhood sexual abuse (CSA) trauma. Sexual abuse has been associated with symptomatology similar to *Posttraumatic Stress Disorder* (PTSD), (APA, p. 424-429; Farrell & Hains, 1998; Shapiro & Follette, 2001). CSA survivors have reported experiencing intrusive symptomatology that reminds them of the initial trauma. These intrusive symptoms often result from a lack of control of psychological defenses. The symptoms could include recurrent thoughts and images of the abuse, intrusive feelings and bodily sensations, nightmares, insomnia and concentration difficulties (Dodds, 1996; King, Tonge, Mullen, Myerson, Heyne, Rollings, Martin, & Ollendick, 2000; King, Tonge, Mullen, Myerson, Heyne, Rollings, & Ollendick, 2000; Hall & Henderson, 1996; Palm & Follette, 2001).

Some researchers have connected the sexual abuse survivor's cognitive factors (perceptions of the abuse and attributional style) with the development of PTSD (Farrell & Hains, 1998; King et al., 2000b). Often the CSA survivor's development and information processing system has been arrested or disrupted. CSA survivors may also develop restricted coping strategies and cognitive distortions related to the self, others and/or the future that may persist into adulthood.

Often the CSA survivor may develop secondary symptomatology that includes cognitive assumptions of self-blame and guilt that subverts self-esteem and self-worth (King, et. al., 2000b). This poor self-concept and self-image can be linked with the survivor engaging in self-destructive and deleterious behaviors such as drug and alcohol abuse, self-mutilation or

dissociation (Draucker & Spradlin, 2001; Moncrieff, & Farmer, 1998; Wilsnack, et al., 1997). Some researchers have suggested that the survivor may have developed post-sexual trauma symptoms as mechanisms of escaping from or coping with the sexual abuse (Dodds, 1996; Palm & Follete, 2001).

One form of post-sexual symptomatology is the formation of *avoidance symptoms*, in which sexual abuse survivors attempt to avoid any reminders, intrusive thoughts or feelings associated with the abuse (Palm & Follette, 2001). This *experiential avoidance* is an excessive use of psychological defenses (e.g., denial, numbing of emotions and thoughts) associated with the trauma, and results in interfering with the psychological processing of the sexual abuse experience. The CSA survivor experiences ambivalence and confusion due to vacillation between intrusive and avoidance symptoms associated with the sexual abuse trauma. Avoidance of the sexual abuse trauma provides short-term relief for the survivor, but has long-term deleterious symptomatological effects, thus complicating and often interfering with recovery.

Summary Of Recent Empirical Research

In recent years, there has been an influx of research on sexual abuse trauma, PTSD symptomatology, and the efficacy of cognitive behavioral interventions (Edmond, et al., 1999; Farrell & Hains, 1998; Hall & Henderson, 1996; King, et. al., 2000a; King, et. al., 2000b; Nishith, et al., 1995; Palm, & Follete, 2001; Parnell, 1999; and Shapiro & Maxfield, 2001). Currently, there are only 2 APA approved empirically supported treatments for trauma. The first is exposure-based cognitive-behavioral treatments, which include *Imaginal* or *In Vivo flooding* and *systematic desensitization*, such as *stress inoculation therapy* (SIT). The second APA approved treatment is *Eye Movement Desensitization and Reprocessing* (EMDR), (Palm & Follette, 2001; Shapiro, 2003). However, for purposes of brevity and some research and methodological problems, EMDR will not be addressed in this paper.

Nishith, Hearst, Mueser, & Foa, (1995) have shown the efficacy of the use of cognitive behavioral treatments, utilizing *stress inoculation therapy* (SIT), cognitive restructuring and *prolonged imaginal in vivo exposure* (PE) for women diagnosed with assault-related PTSD and comorbid major depression. Research on sexually abused children with PTSD symptomatology suggested that the use of cognitive behavioral interventions was effective in challenging the maladaptive thought processes and affective disturbances related to the sequelae of sexual abuse (Farrell & Hains, 1998).

King, et al. (2000a) found that cognitive-behavioral treatment was efficacious in the treatment of sexually abused children with PTSD symptomatology, significantly reducing PTSD symptoms of reexperiencing, avoidance, and hyperarousal. The study also found that children and caregivers perceived CBT in a positive light.

King, et al., (2000b) had incorporated child therapy with CBT in the treatment of sexually abuse children. Their study found support for the use of structured cognitive-behavioral interventions when dealing with sexually abused children with PTSD symptomatology. Rather than avoidance of the topic, children were encouraged to confront painful memories, intense anxiety, shame and guilt related to the sexual abuse. King utilized CBT techniques involving coping skills training, relaxation training, behavior rehearsal, and cognitive therapy (recognition and assessment of self-talk). Pictorial material involving cartoons with thought bubbles assisted in appropriate self-talk. Assertiveness training, as well as graded exposure utilizing imagination, drawings, role-play activities, writing stories, and discussions were incorporated. Near the end of treatment, children were exposed to relapse prevention and education (e.g., body ownership, saying *no*, and appropriate touching).

Dodds (1996) found some evidence of support for the use of Trauma Focused Therapy (TFT) with survivors of sexual abuse. Participants in this study reported reduction in fear and intrusive symptoms from exposure and symbolic representation during group therapy. An additional benefit reported was the ability to share the details of the abuse within a group setting. However, the hypothesis that TFT would be more effective than Effect Focused Therapy (EFT) was not supported. One possible reason provided was that the participants were not sufficiently exposed to the treatment long enough for lasting effects to occur. Positive treatment outcome was related to the intensity and length of exposure- the greater the anxiety reaction, the greater the reduction in anxiety (Kozak, 1988, as cited in Dodds, 1996).

Interventions and Treatment Approaches

Cognitive behavioral treatment (CBT) interventions require trauma survivors to directly confront their painful memories (King, et al., 2000b). CBT shifts the survivor's focus from avoidance or control of the intrusive thoughts and feelings to acceptance, confronting, and changing the typical responses to these experiences. The survivor's exposure to the traumatic event provides an opportunity to process the experience, which will result in dissipation of symptomatology (Palm & Follette, 2001).

CBT requires that the survivor provide written accounts of the trauma. This allows for assessment of the survivor's cognitive distortions that are to be challenged and reframed (Hall & Henderson, 1996). Part of exposure treatment involves training the client in stress management, distress tolerance and/or coping skills. Anxiety management techniques can be utilized as along with intrusive symptoms and exposure techniques to address avoidance reactions (Dodds, 1996).

The client's level of distress can be measured utilizing the subjective units of distress (SUD) scale (Bradley, 2001; Palm & Follette, 2001), in which the client self-monitors the distress on a scale of 0 (*not distressed*) to 10 (*extremely distressed*). It is also important to address and normalize with the survivor the *experiential avoidance* as a means of avoiding intrusive physiological and emotional reactions to the trauma prior to and during the therapy process. Therapy should take a contextual and non-blaming stance in which those behaviors that are counterproductive are suggested as amendable.

Exposure Treatments

There are two forms of exposure treatment: *Imaginal* and *In vivo*. These treatments gradually expose the survivor to safe situations and circumstances associated with the trauma, thus habituating the victim to anxiety and fear in order for cognitive restructuring to occur. In *imaginal* exposure, the client provides the details of the abuse in the present tense along with descriptions of emotional and physiological reactions (Palm & Follette, 2001). The client is encouraged to begin with details that evoke low to moderate levels of anxiety, gradually increasing in details, while self-monitoring the SUD scale rating. This process continues until the anxiety is relatively low. *In vivo* exposure encourages the survivor to confront avoided situations that remind him/her about the abuse (e.g., intimate relationships). A hierarchy of fears is created and assigned a SUD rating, in which the survivor gradually confronts each fear (Palm & Follete, 2001).

One from of systematic desensitization that is effective with intrusive symptoms is *Stress Inoculation Training* (SIT). SIT educates the survivor in a variety of coping skills to manage fear, hyperarousal, and reduction of avoidance behaviors (Nishith, et al., 1995). Nishith et al., (1995), utilized the following SIT techniques: Cognitive restructuring, self-guided dialogue, role-play, and covert modeling to alleviate thoughts of worthlessness, hopelessness & remission of depression. Relaxation training and calm breathing were also used to decrease physiological arousal.

Implications for Counseling Practice

The treatment of sexual abuse with survivors is a delicate and complex process. It is important to observe the symptomatology and behavior of the client, rather than focusing solely on the content or verbal responses of the survivor. Practice and skill is required in observing and interpreting the survivor's non-verbal and physiological reactions throughout the therapy process. Pushing the client too far or too quickly can have a rebound effect, in which the survivor engages in *experiential avoidance* of the topic. It is imperative that the therapist provides and establishes a safe environment and trusting relationship prior to any in-depth cognitive restructuring (Palm & Follete, 2001).

The survivor may have adopted a very passive stance due to the lack of options and control during the abuse. For this reason, it is extremely important that the therapist acquire informed consent from the survivor about the process of exposure-based therapy prior to initiating any form of treatment. This will allow the survivor to gain feelings of control as well as take responsibility for the process of healing and change. In addition, a thorough assessment of the survivor's complaints, history, current problems and any current factors maintaining those problems should be completed, focusing on the most relevant issues first.

Palm & Follette (2001) suggest that the fundamental goal of treatment is, "acceptance of the self and adoption of commitment to new behaviors that are consistent with client identified life goals", (p.85). Considering the existence of the survivor's sensitivity to external cues (hyperarousal) and capacity for negative self-perceptions due to the traumatic sexual abuse experiences, it is important for the therapist to not react with horror or disgust when the survivor shares past history of abuse. As part of the coping process of ongoing therapy, a helpful and necessary component to include is to assist in increasing the survivor's positive self-concept and development of assertiveness.

In the course of treatment, the survivor may also present with anger, guilt, shame, dissociative episodes, and/or engage in transference. It is important that the therapist maintain a balance in boundaries with the survivor, normalizing the reactions and modeling proper demonstration of emotions. Part of the process of healing from CSA is placing responsibility on the perpetrator(s) and releasing of self-shame and guilt. This process can often be facilitated through letterwriting (healing letter), or through symbolic confrontation. Imagery or guided relaxation techniques that assist in diffusing some of the trauma associated with sharing of

experiences can often be combined with exposure-based treatments. Lastly, to those therapists who have had personal experience with sexual abuse, it is important to be constantly aware of any countertransference with the survivor.

This paper has briefly summarized some of the treatment issues when utilizing exposure-based CBT. Due to the complexity of CSA and the sensitivity required in counseling, it is vital that professionals understand the impact of using exposure-based therapy. Recent research supports the efficacy of the use of exposure-based CBT. However, utilizing any exposure-based CBT in working with sexual abuse survivors takes considerable thought, time, trust-building, and careful skill. CBT should be done only with adequate training and experience. Regardless of the method or techniques utilized, therapists should keep in mind the ethical principles and legal issues related to treating sexual abuse survivors. Sexual abuse survivors view therapists who display the characteristics of support, understanding, concern, care, empathy, and compassion as most helpful (Barnes, 1995; Palmer, et al., 2001).

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